



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Texas Health Arlington

**Respondent Name**

Poly America LP

**MFDR Tracking Number**

M4-15-1431-01

**Carrier's Austin Representative**

Box Number 11

**MFDR Date Received**

January 12, 2015

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Since TDI moved to a 200% of MAR for outpatient services on 3/1/08 for hospital claims, we have reviewed the Medicare allowance and decided the insurance reimbursement does not meet this criteria."

**Amount in Dispute:** \$3,915.48

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute received however no position statement submitted.

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 5 – 8, 2014	Outpatient Hospital Services	\$3,915.48	\$3,915.48

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
  - 193 – Original payment decision is being maintained

**Issues**

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

## **Findings**

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on January 21, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.
2. 28 Texas Administrative Code §134.403 states in pertinent part (f) The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code J7120 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code A4565 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 36415, date of service May 5, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 85027, date of service May 5, 2014, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 73130 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$57.35. This amount multiplied by 60% yields an unadjusted labor-related amount of \$34.41. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$32.86. The non-labor related portion is 40% of the APC rate or \$22.94. The sum of the labor and non-labor related amounts is \$55.80. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$55.80. This amount multiplied by 200% yields a MAR of \$111.60.
  - Procedure code 76001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
  - Procedure code 26727 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0062, which, per OPPS Addendum A, has a payment rate of \$2,012.19. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,207.31. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$1,152.86. The non-labor related portion is 40% of the APC rate or \$804.88. The sum of the labor and non-labor related amounts is \$1,957.74. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$1,957.74 divided by the sum of all S and T APC payments of \$3,941.87 gives an APC payment ratio for this line of 0.496653, multiplied by the sum of all S and T line charges of \$7,575.75, yields a new charge amount of \$3,762.52 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$1,957.74. This amount multiplied by 200% yields a MAR of

\$3,915.48.

- Procedure code 26727 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0062, which, per OPPS Addendum A, has a payment rate of \$2,012.19. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,207.31. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$1,152.86. The non-labor related portion is 40% of the APC rate or \$804.88. The sum of the labor and non-labor related amounts is \$1,957.74. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$978.87 divided by the sum of all S and T APC payments of \$3,941.87 gives an APC payment ratio for this line of 0.248326, multiplied by the sum of all S and T line charges of \$7,575.75, yields a new charge amount of \$1,881.26 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$978.87. This amount multiplied by 200% yields a MAR of \$1,957.74.
- Procedure code 26727 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 0062, which, per OPPS Addendum A, has a payment rate of \$2,012.19. This amount multiplied by 60% yields an unadjusted labor-related amount of \$1,207.31. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$1,152.86. The non-labor related portion is 40% of the APC rate or \$804.88. The sum of the labor and non-labor related amounts is \$1,957.74. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$978.87 divided by the sum of all S and T APC payments of \$3,941.87 gives an APC payment ratio for this line of 0.248326, multiplied by the sum of all S and T line charges of \$7,575.75, yields a new charge amount of \$1,881.26 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is \$978.87. This amount multiplied by 200% yields a MAR of \$1,957.74.
- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2001 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J2405 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 93005, date of service May 5, 2014, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0099, which, per OPPS Addendum A, has a payment rate of \$27.12. This amount multiplied by 60% yields an unadjusted labor-related amount of \$16.27. This amount multiplied by the annual wage index for this facility of 0.9549 yields an adjusted labor-related amount of \$15.54. The non-labor related portion is 40% of the APC rate or \$10.85. The sum of the labor and non-labor related amounts is \$26.39. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than \$1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status

indicator S or T line item with a billed charge less than \$1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of \$26.39 divided by the sum of all S and T APC payments of \$3,941.87 gives an APC payment ratio for this line of 0.006695, multiplied by the sum of all S and T line charges of \$7,575.75, yields a new charge amount of \$50.72 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,900. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$26.39. This amount multiplied by 200% yields a MAR of \$52.78.

3. The total allowable reimbursement for the services in dispute is \$7,995.34. The amount previously paid by the insurance carrier is \$4,079.85. The requestor is seeking additional reimbursement in the amount of \$3,915.48. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$3,915.48.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$3,915.48, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

_____	_____	May 20, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**